

Evidence Based Guidelines: To Improve Colorectal Cancer Screening

'We now have clearer insight into the natural history of colorectal cancer and clinical skills with which to intervene and make a difference for many people. Colorectal cancer screening has come of age'.

--Sidney J. Winawer, MD

Presented to you by:



American Cancer Society

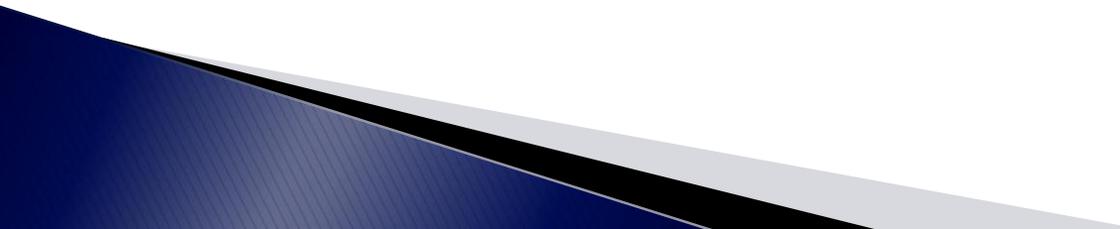
Unless otherwise identified, all information
is derived from the
2006 American Cancer Society handbook,

**‘How to Increase Colorectal
Cancer Screening Rates in Practice: A Primary Care
Clinician’s Evidence-Based Toolbox and Guide’.**

Disclosures

- ▶ This webinar is **Non–Peered Reviewed** and brought to you through Nebraska Department of Health and Human Services
- ▶ The Nebraska Licensing Unit allows for 1.5 non–peer reviewed Contact Hours per licensing cycle
 - For more information on licensing information:
http://dhhs.ne.gov/publichealth/Pages/crl_nursing_nursingindex.aspx
- ▶ This webinar is worth 1.5 Contact Hours

Goals

- Enhance clinicians opportunities to prevent colorectal cancer with appropriate screening.
 - Decrease mortality and morbidity of colorectal cancer in Nebraskans.
 - Reduce disparities by applying screening guidelines on a universal basis to the age-appropriate population.
 - Improve preventive care in primary care practices through use of strategies and tools.
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Learning Objectives

- ▶ The primary care provider shall:
 - Describe four office essentials to enhance colon cancer screening rates.
 - Identify risks and costs associated with colorectal cancer.
 - Discuss colon cancer screening recommendations for individuals at average, medium and high risk of developing colon or rectal cancer.

Learning Objectives

- Through colon cancer screening, the patient shall:
 - Have decreased risk of developing polyps.
 - Have lower risk of developing colorectal cancer.
- With education the patient shall:
 - Recognize the importance of colon cancer screening.
 - Recognize the importance diet and exercise may play in the development of colon cancer.
 - Recommend colon cancer screening to other family members and within a community.

Why Colon Cancer Screening is Important

- ▶ Screening prevents colorectal cancer and reduces mortality.
- ▶ New insurance reporting requirements include your practices' screening rates.
- ▶ Malpractice cases involving colorectal cancer are costly.

www.ahrq.gov/clinic/uspstf/uspscolo.htm

Why Colon Cancer Screening is Important

- ▶ Consequences of a missed opportunity to prevent Colorectal Cancer (CRC) or to diagnose it prior to spreading can be life-threatening and lead to substantial morbidity.
- ▶ Public awareness is growing which increases legal jeopardy and financial loss.
- ▶ A delay in diagnosis and the mismanagement of diagnostic testing are currently the main complaints made in malpractice cases that involve CRC.

Why Colon Cancer Screening is Important

- ▶ Colorectal cancer is both the nation's second leading cause of cancer mortality and one of the most preventable cancers.
- ▶ CRC is second to lung cancer as a cause of cancer deaths and shares with lung cancer the unusual distinction of being a largely preventable disease.
- ▶ In 2006, Nebraska was ranked the 4th highest in Colorectal Cancer deaths. In 2010, Nebraska was still ranked number 11.
- ▶ Finding and treating colorectal cancer early may prevent death from colorectal cancer.

Cost Benefits

- ▶ Cost of screening is typically less than the cost of treating cancer.
- ▶ When screening identifies a colorectal tumor in its early stages, the cost of treatment is often much less expensive than if the tumor is detected later in the course of the disease.

Seifeldin R, Hantsch JJ. The economic burden associated with colon cancer in the United States. Clinical Therapeutics, 1999;21(8):1370-1379.

Cost Benefits

- ▶ Colorectal cancer is a disease of middle and old age, therefore the costs related to colorectal cancer treatment are likely to increase as the population ages.
- ▶ Hospital admissions for colorectal cancer are expected to double by 2050.
- ▶ The estimated annual national expenditure for colorectal cancer treatment is \$5.5–\$6.5 billion. (Inpatient hospital care accounts for 80% of this cost.)

Seifeldin R, Hantsch JJ. The economic burden associated with colon cancer in the United States. Clinical Therapeutics, 1999;21(8):1370–1379.

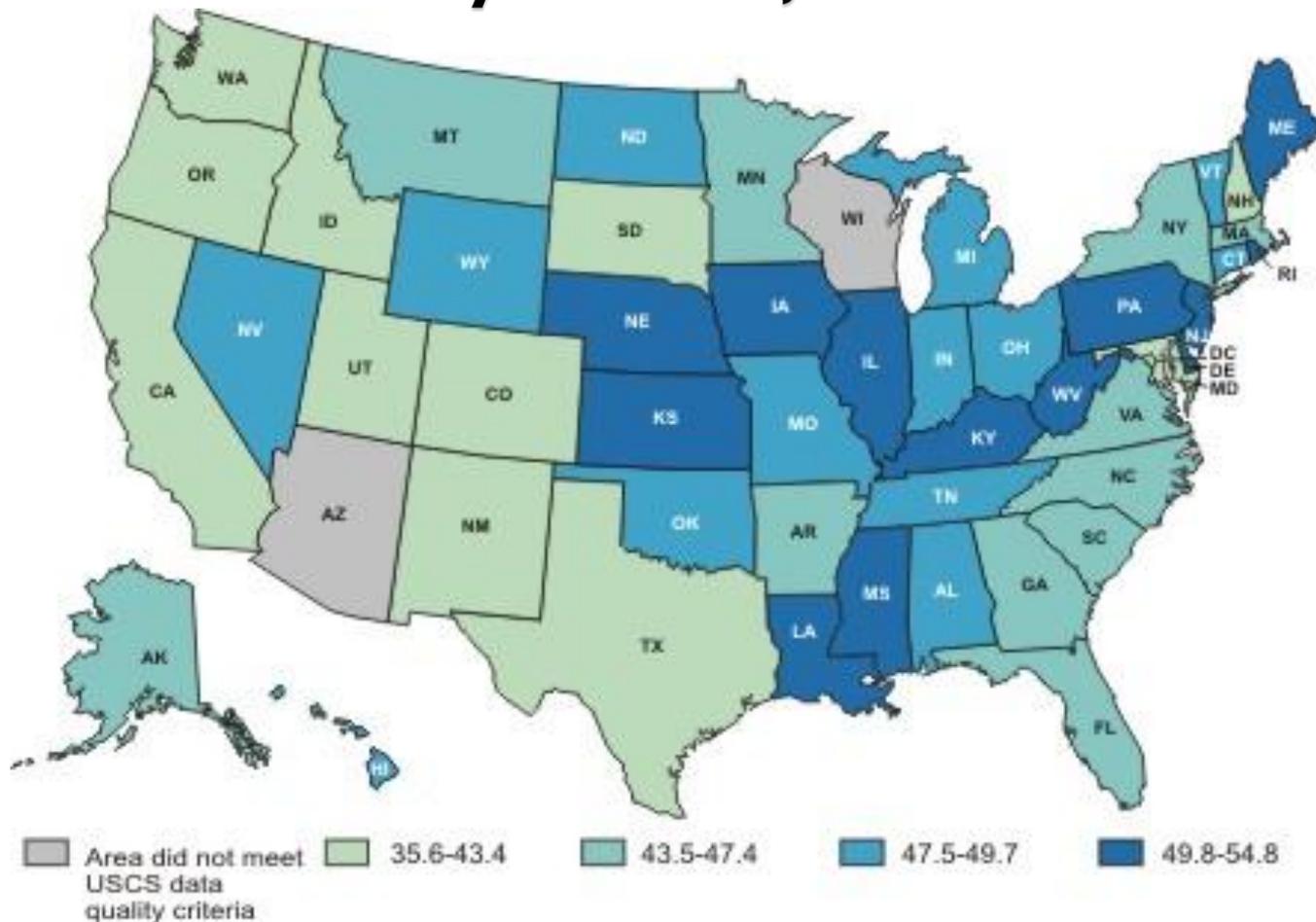
Cost Benefits

- ▶ Based on census projections, the annual number of colon cancer-related hospital admissions:
 - Persons age 50 – expected to increase from 215,000 in 1992 to 471,000 in 2050.
 - Persons age 60 years and older – expected to increase from 192,000 in 1992 to 448,000 in 2050.

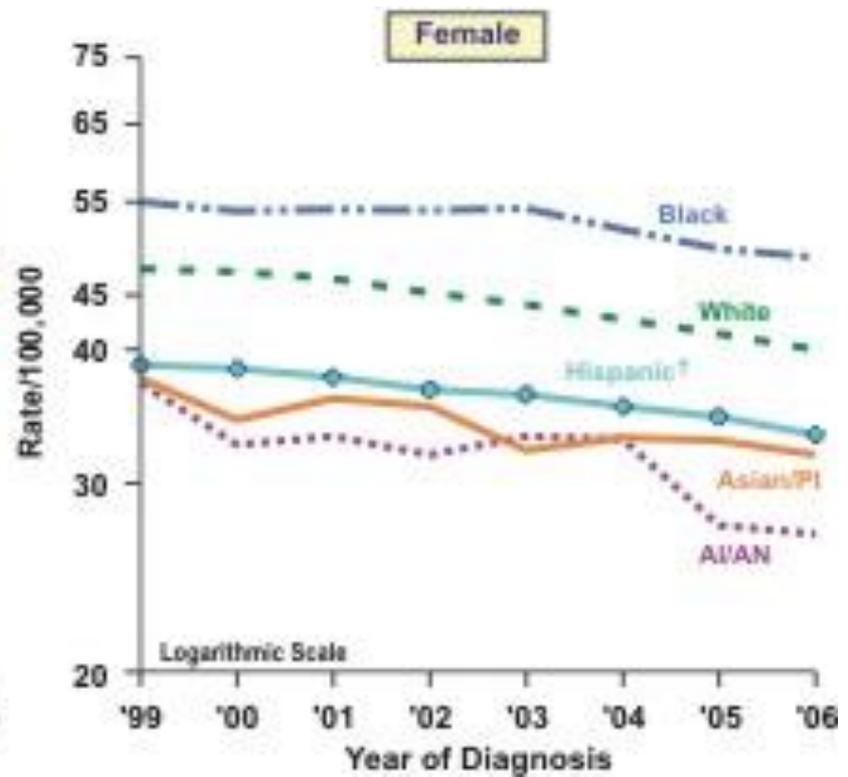
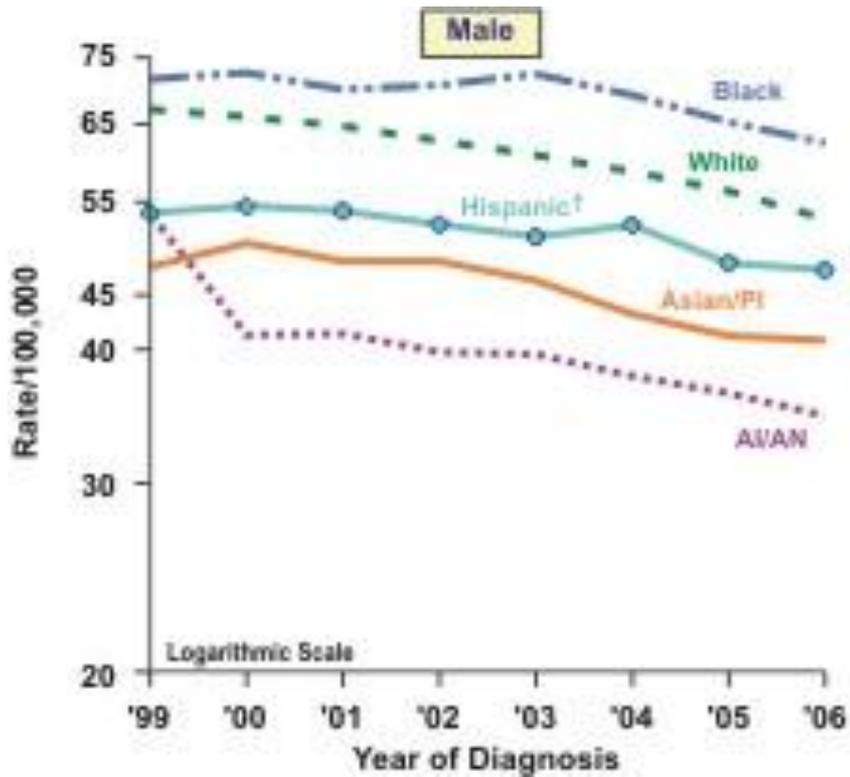
Seifeldin R, Hantsch JJ. The economic burden associated with colon cancer in the United States. Clinical Therapeutics, 1999;21(8):1370-1379.

www.businessgrouphealth.org

Colorectal Cancer Rates, *by State, 2006



Incident Rates by Race



www.cdc.gov/cancer/colorectal/statistics/race.htm

Colon Cancer Diagnosis

Year 2006 per 100,000

- ▶ African-American Men 68.1
- ▶ Caucasian men 54.4

- ▶ African American women 52.6
- ▶ Caucasian Women 40.9

- ▶ Statistics for other minority groups were:
 - Asian Pacific Islander: Men – 45.5 Women 34.12
 - American Indian/Alaska Native: Men 43.4 Women 40.4
 - Hispanic: Men 44.5 Women 31.6

Uncontrollable Risks Factors for Colon Cancer

- Age
- Race
- A family history of cancer of the colon or rectum.
- Hereditary conditions, such as Familial Adenomatous Polyposis (FAP) and hereditary nonpolyposis colon cancer (HNPCC; Lynch Syndrome).
- A history of polyps in the colon.
- A history of ulcerative colitis.
- A history of Crohn's Disease.

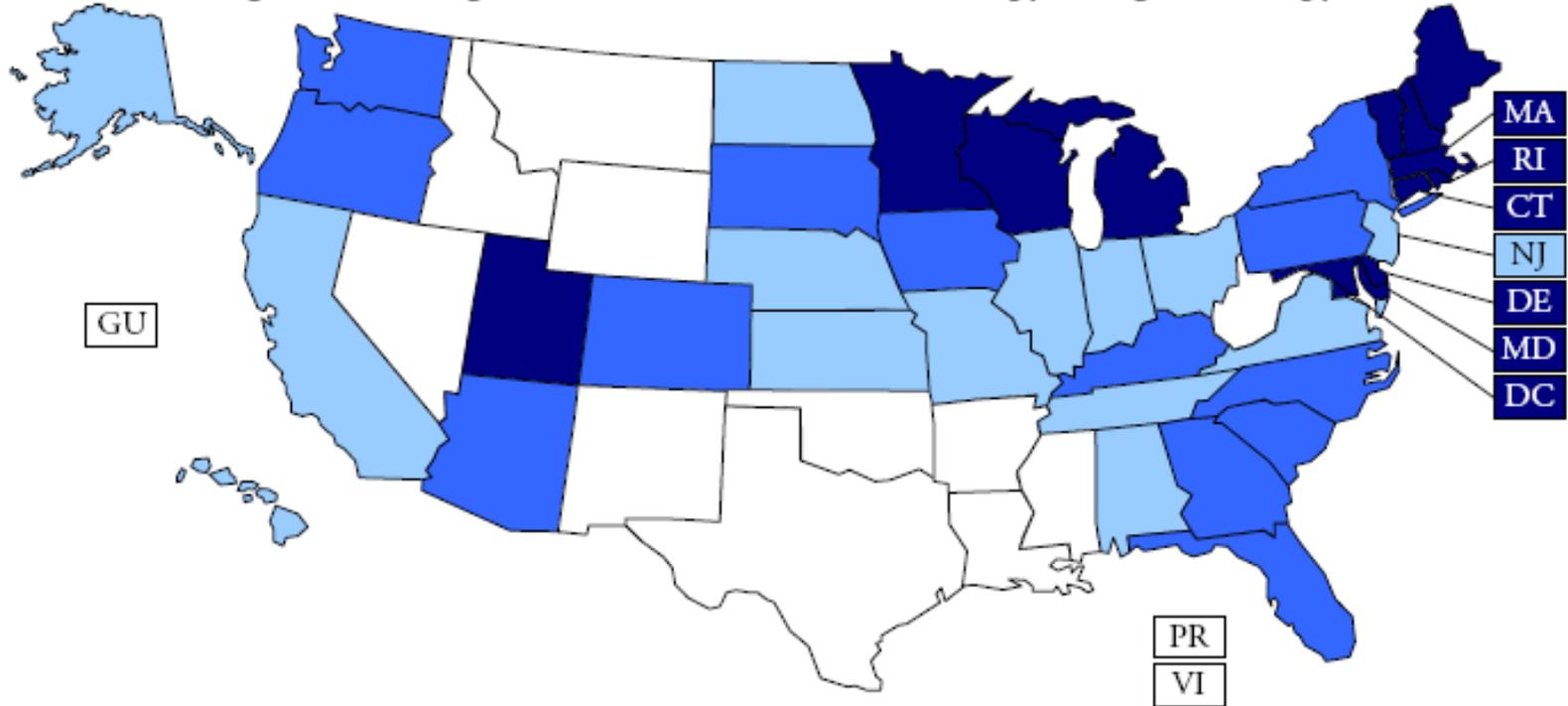
Controllable Risks Factors for Colon Cancer

- ▶ Obesity has been reported to increase the risk of colon cancer, especially in men.
 - Mortality from colorectal cancer is significantly elevated in men who were $\geq 40\%$ overweight.

Controllable Risks Factors for Colon Cancer

- ▶ Smoking increases your risk of developing colon cancer.
 - Inhaled or swallowed tobacco smoke transports carcinogens to the colon.
 - Tobacco use seems to increase polyp size.
 - Smoking a pack a day may increase risk by 40%.

Percentage of Those Age 50+ Who Have Had Colonoscopy or Sigmoidoscopy (2008)



- Above 67 Percent
- 61.9 To 67 Percent
- 57 To 61.8 Percent
- Below 57 Percent

*61.8 percent is the national rate of screening.

Prevention

The American Cancer Society recommends:

- Choosing foods and beverages to maintain a healthy weight.
- Eating 5 or more servings of vegetables and fruits daily.
 - Diets high in vegetables and fruits have been linked with lower risk of colon cancer
- Choosing whole grains rather than processed (refined) grains.
- Limiting your intake of processed foods and red meats.
 - Diets high in processed and/or red meats have been linked with a higher risk

Prevention

American Cancer Society recommends:

- Maintain healthy weight – Obesity raises the risk of colon cancer in both men and women, but the link seems to be stronger in men.
- Exercise – adults should get at least 30 minutes of moderate or vigorous physical exercise on 5 or more days of the week.

Prevention

American Cancer Society recommends:

- ▶ Avoid excessive alcohol intake – no more than 1 drink per day for women or 2 for men.
- ▶ Aspirin use – studies show that people who regularly use aspirin have a lower risk of colorectal cancer and Adenomatous polyps.

Prevention

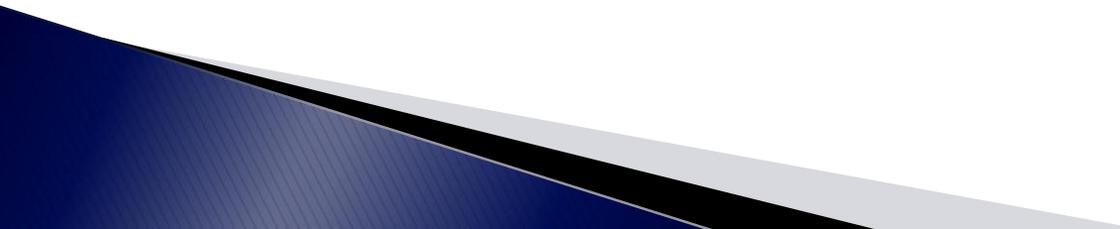


Test your knowledge

- ▶ At what age should a man or woman at average risk for colon cancer begin screening?
 - A. Age 60
 - B. Age 50
 - C. It doesn't matter

B. Age 50

Four Essentials To Improve Screening Rates

1. Your Recommendation.
 2. An Office Policy.
 3. An Office Reminder System.
 4. An Effective Communication System.
- 

#1 Your Recommendation

- Implementing an office practice that assures every age-appropriate or at risk client receives a screening recommendation will:
 - Start increasing colorectal screening rates
 - Decrease incidences of colon and rectal cancer

Your Recommendation

Patients do things their physician recommends.

- The positive impact of advice from a doctor to get cancer screening is well documented.
- 90% of people screened for colon cancer reported doing so because their physician recommended it compared to 17% of those who reported no provider recommendation.

Your Recommendation

- 72% of those whose physician recommended an FOBT completed it compared to 8% of those whose physician had not.
- Strongly influences all ethnic and racial groups.
 - Addresses cultural concerns.
 - Removes barriers.
 - Educates and provides facts.

Identify Processes

- ▶ State your agency goal – Prevent CRC by removing adenomatous polyps that can turn into colorectal cancer.
 - ▶ Know the current history of each client served.
 - ▶ Develop confidence in screening tests and their effectiveness.
- 

Understand Current Screening Guidelines

- ▶ Outdated Knowledge:
 - The digital rectal exam (DRE) is **not** accepted practice.
 - A single FOBT in the office is **not** evidence-based.
 - A positive FOBT should **not** be dismissed as a likely false positive test. It requires a follow-up colonoscopy.

Identify Resources

- ▶ Identify options for screening in your area (i.e. specialty physicians, insurance requirements, etc.)
 - Cost of an FOBT is low and the colonoscopy cost is declining.
 - Consult health departments where the uninsured can access complete diagnostic examinations.
 - Discuss the barrier of co-pay and deductibles.

Test your knowledge

The digital rectal exam (DRE) is an accepted CRC screening practice?

- A. True
- B. False

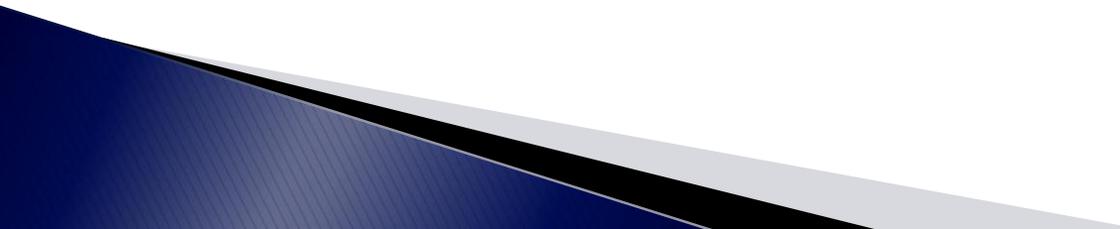
B. False

Nebraska Colon Cancer Program (NCP)

- ▶ The goal of NCP is to increase colon cancer screening while reducing colon cancer diagnoses and mortality.
 - ▶ Funded by the Center for Disease Control and Detection (CDC), NCP was added to the Nebraska Office of Women's and Men's Health in 2005.
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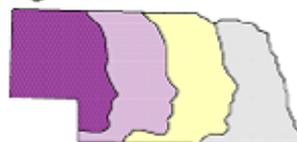
NCP Eligibility Guidelines

(Set by the Medical Advisory Committee)

- ▶ Must be a Nebraska Resident.
 - ▶ Man or Woman age 50 – 75.
 - ▶ Must meet income guidelines set by the program (225% of or below poverty level).
 - ▶ Can be on Medicare, Medicaid and have insurance (except for an HMO policy).
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NCP Income Guidelines UPDATE

Every Woman Matters



NEBRASKA OFFICE OF WOMEN'S HEALTH



Yearly Income Eligibility Scale

Effective

July 1, 2010 - June 30, 2011

Nebraska Health & Human Services

Every Woman Matters

1-800-532-2227

# of People in Household (including woman enrolling)	FREE	\$5.00 Donation
1	0 - \$10,830	\$10,831 – 24,368
2	0 - \$14,570	\$14,571 – 32,783
3	0 - \$18,310	\$18,311 – 41,198
4	0 - \$22,050	\$22,051 – 49,613
5	0 - \$25,790	\$25,791 – 58,028
6	0 - \$29,530	\$29,531 – 66,443
7	0 - \$33,270	\$33,271 – 74,858
8	0 - \$37,010	\$37,011 – 83,273
9	0 - \$40,750	\$40,751 – 91,688
10	0 - \$44,490	\$44,491–100,103
11	0 - \$48,230	\$48,231–108,518
12	0 - \$51,970	\$51,971–116,933

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System.
#US8/DP000811, #US8/DP001421, #US8/DP002043-01

Based on Risk NCP Offers Either

1. Fecal Occult Blood Test (FOBT)

- If a client tests positive NCP will pay for a colonoscopy to complete the diagnosis.

2. Colonoscopy

- NCP will cover pathology fees if polyps were removed or biopsies taken.
- If necessary, the colonoscopy can be performed under Monitored Anesthesia Care (MAC).
- If the colonoscopy was unsuccessful, NCP may be able to assist with a Double Contrast Barium Enema.

NCP Enrollment

- ▶ Every Woman Matters Program (EWM) clients over age 50 receive an enrollment form along with information on screening.
- ▶ Call 800-532-2227 for an enrollment form.
- ▶ Visit the website at stayinthegamene.com
- ▶ <http://www.hhs.state.ne.us/crc/>

Test your knowledge

- ▶ The Nebraska Colon Cancer Program is for women only?
 - A. True
 - B. False

B. False

#2 An Office Policy

“Almost all primary care physicians recommend screening for CRC. Few have systems in place to assure that all eligible patients get the recommendation”. ...Richard Wender, MD , 2003

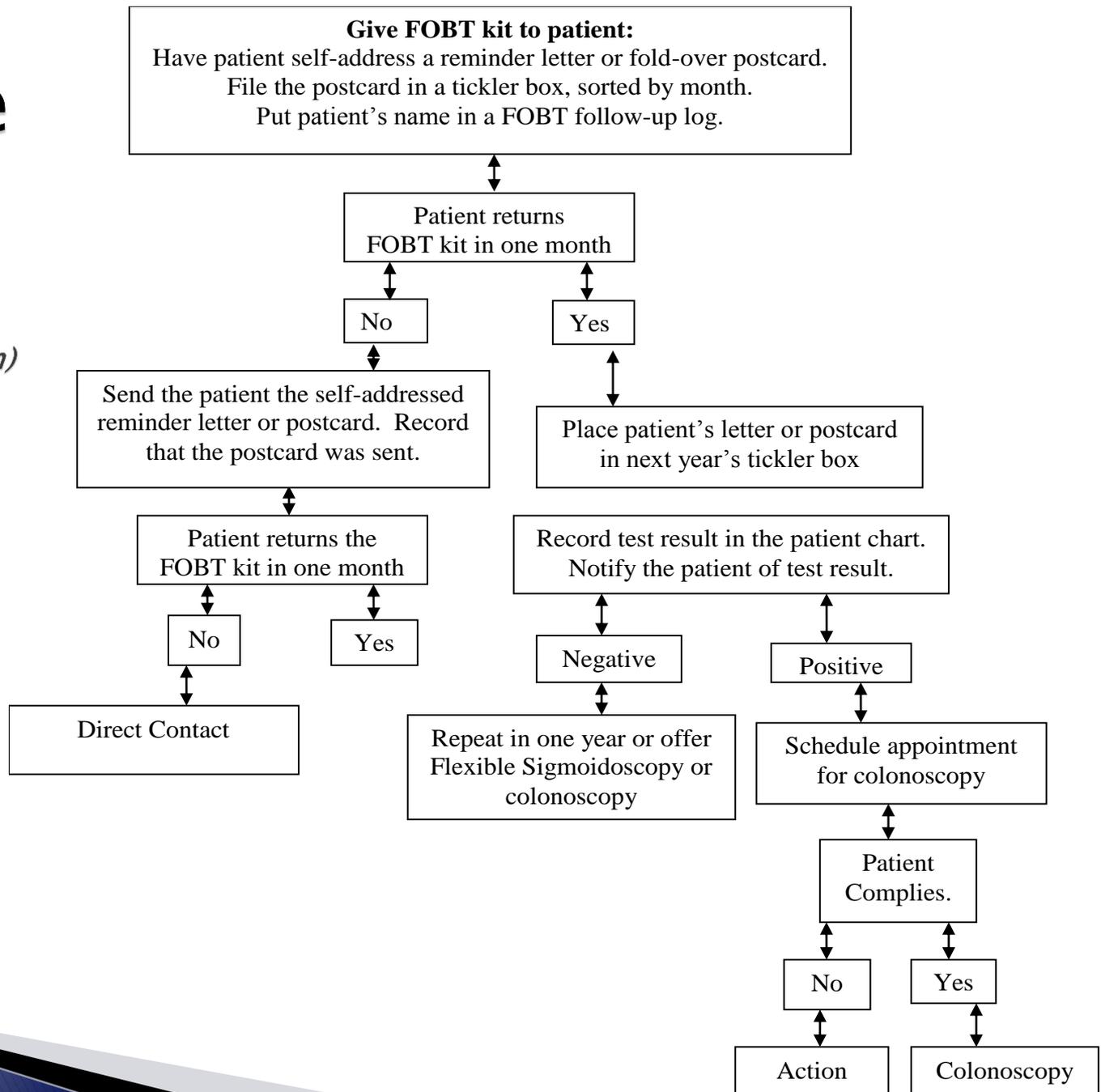
- ▶ An Office Policy is the foundation of a systematic approach
 - Develop to address differing risk levels.
 - Develop to meet the needs of the practice.
 - Develop to determine individual risk levels.

An Office Policy

- ▶ Identify Local Medical Resources.
 - ▶ Assess Insurance Coverage.
 - ▶ Consider Patient Preference.
 - ▶ Attend to Office Implementation.
 - Present the policy to staff.
 - Post the policy.
 - Engage the staff.
- 

Sample FOBT Policy

(in flow chart form)



Malpractice Facts

- ▶ “Failure to diagnose” had been the dominant malpractice complaint, especially where patients presented with symptoms.
- ▶ A newer version of this complaint, “failure to screen”, is rising in frequency as a principal accusation, especially for patients at increased risk.

Malpractice Facts

- ▶ Delay in diagnosis of breast cancer is the leading cause of all malpractice suits against physicians.
- ▶ Delays in diagnosis of lung and colorectal cancer are among the most expensive in terms of indemnity payment.

Physicians Insurance Association of America, February 2006

Insurance Reporting Requirements

- ▶ The Health Plan Employer Data and Information Set (HEDIS) that is disseminated by the National Committee for Quality Assurance (NCQA) is required for all employer health plans includes colorectal cancer screening rates on the standard list of quality measures.
- ▶ Many primary care physicians will soon be required to report their CRC screening rates.
- ▶ This information will be presented and available to the public.

Test your knowledge

- ▶ Of the following, which is the most effective method of enhancing colorectal cancer screening?
 - A. An office policy
 - B. A physician or clinician

B. A physician or clinician

#3 An Office Reminder

- ▶ Helps clients be reminded when to receive appropriate colorectal cancer screenings.
 - ▶ Increases the chances of the clients following through with recommendations.
 - ▶ Provides an opportunity to answer questions and educate clients.
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An Office Reminder

- Options For Patients:
 - Education
 - Cues to Action

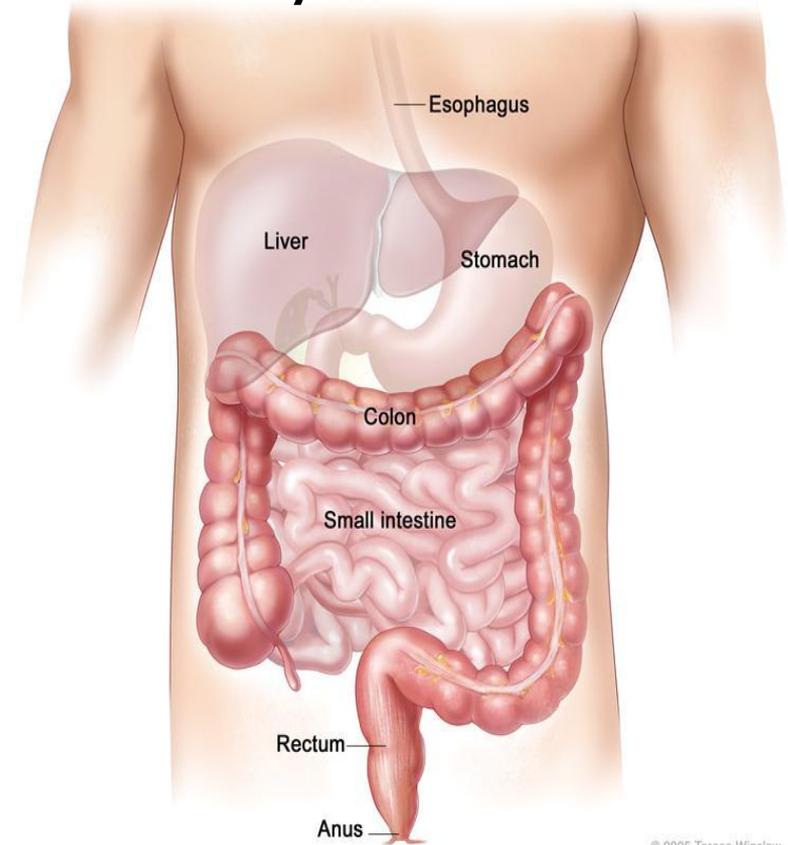
- Options for Clinicians:
 - Chart Prompts/Electronic Reminders
 - Audits and Feedback
 - Ticklers and Logs
 - Staff Assignments

Options for Patients

- ▶ Education
 - State Risk factors
 - State Benefits of screening
 - Offer brochures and literature
- ▶ Cues to Action – must be clear, evidence based, and easy to read
 - Posters
 - Brochures
 - Reminder postcards
 - Reminder letters
 - Reminder calls

Examples
of Posters
easy for
clients to
understand

Digestive System



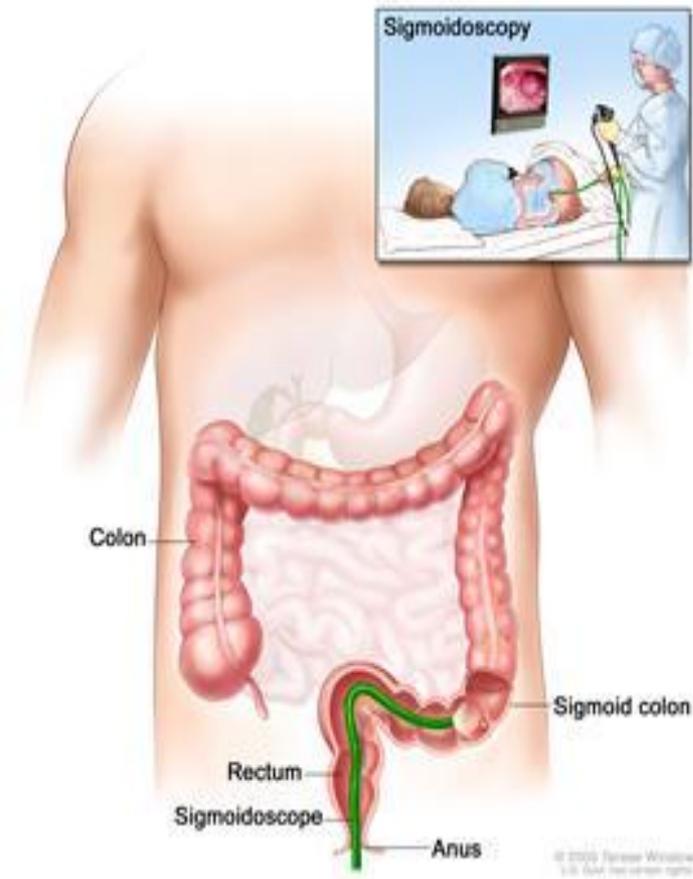
Fecal Occult Blood Test (FOBT)

A test to check stool (solid waste) for blood that can only be seen with a microscope. Small samples of stool are placed on special cards and returned to the doctor or laboratory for testing.



Sigmoidoscopy

A procedure to look inside the rectum and sigmoid (lower) colon for polyps (small pieces of bulging tissue), abnormal areas, or cancer. A sigmoidoscope is inserted through the rectum into the sigmoid colon. A sigmoidoscope is a thin, tube-like instrument with a light and a lens for viewing. It may also have a tool to remove polyps or tissue samples, which are checked under a microscope for signs of cancer.



Colonoscopy

A procedure to look inside the rectum and colon for polyps, abnormal areas, or cancer. A colonoscope is inserted through the rectum into the colon. A colonoscope is a thin, tube-like instrument with a light and lens for viewing. It may also have a tool to remove polyps or tissue samples, which are checked under a microscope for signs of cancer.



Double Contrast Barium Enema (DCBE)

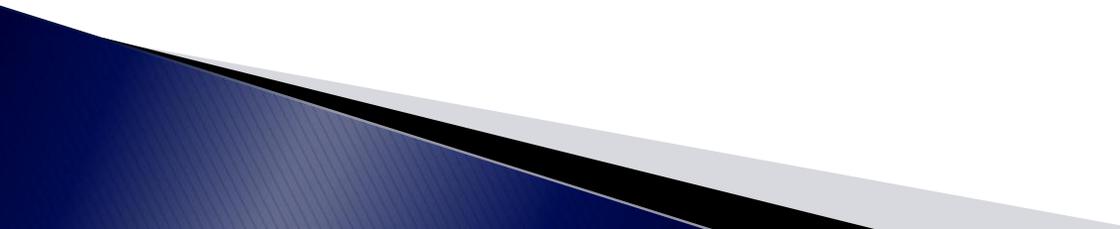
A series of x-rays of the colon and rectum taken after the patient is given an enema, followed by an injection of air. The barium outlines the intestines on the x-rays, allowing many abnormal growths to be visible.

REMEMBER

While there are guidelines set for CRC screening, any screening the client is willing to do is better than NO screening at all!

Options for Clinicians

➤ Chart Prompts

- Place a problem list on each chart to include ‘preventive services’.
 - Add age–appropriate screening schedules.
 - Should be easy to find.
 - Often available from professional, governmental, and insurance–base organizations.
- 

Options for Clinicians

- Chart Reviews and Audits
 - Identifies clients who had positive screenings and need follow up.
 - Should generate reminders that can be pursued immediately by staff.

Test your knowledge

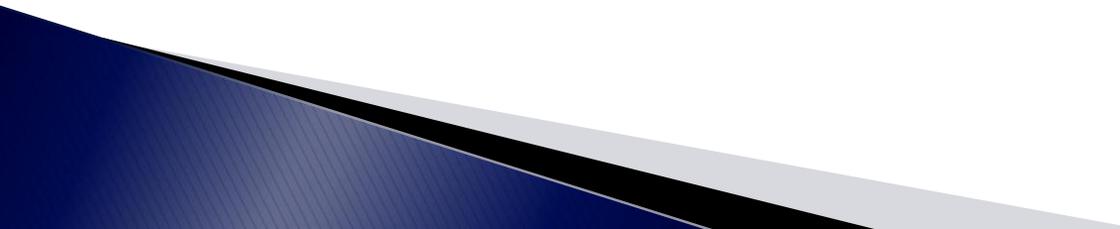
Which of the following have been demonstrated to be effective in raising cancer screening rates?

- A. Postcard reminders
- B. Reminder letters
- C. Telephone calls
- D. all of the above

D. All of the above



System Changes to increase CRC screening rates

- Informing patients ahead of time so they are ready to make a decision when they meet with their provider.
 - Having staff other than the provider present the options to the patient.
 - Sending brochures or education materials to the patient before the appointment.
 - Sending a letter that describes the doctor's recommendation before the visit.
- 

Information Exchange

- **While in the waiting room:**
 - Ask the client to complete a questionnaire that provides information on risk factors, screening history, and attitudes.
 - Place informative and attractive office posters or flyers in the waiting room or exam rooms (show casing the office policy).
 - Customize educational and instructional materials and reminder tools to suit your practice needs.

Information Exchange

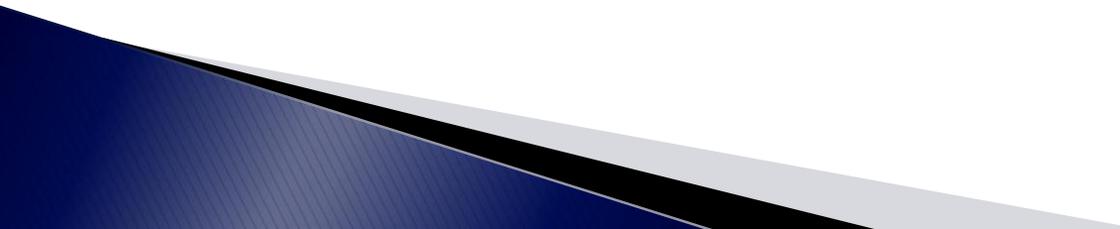
- **At patient check-in:**
 - Have staff ask about preventive care and highlight services that are needed or past due.
 - Use preventative care flow sheets and reminder chart stickers.
- **During the visit:**
 - Ask patients about family history and previous screening.
 - Let patients know that getting CRC screening can prevent cancer and save lives.
 - Schedule screening before the patient leaves the office.

Information Exchange

- **At check-out:**
 - Have patients fill out reminder cards.
 - File the reminder cards by the month and year of planned notification.
- **Communication beyond the office:**
 - Contact patients in need of preventive services for the following month.
 - Telephone reminders of upcoming screenings.

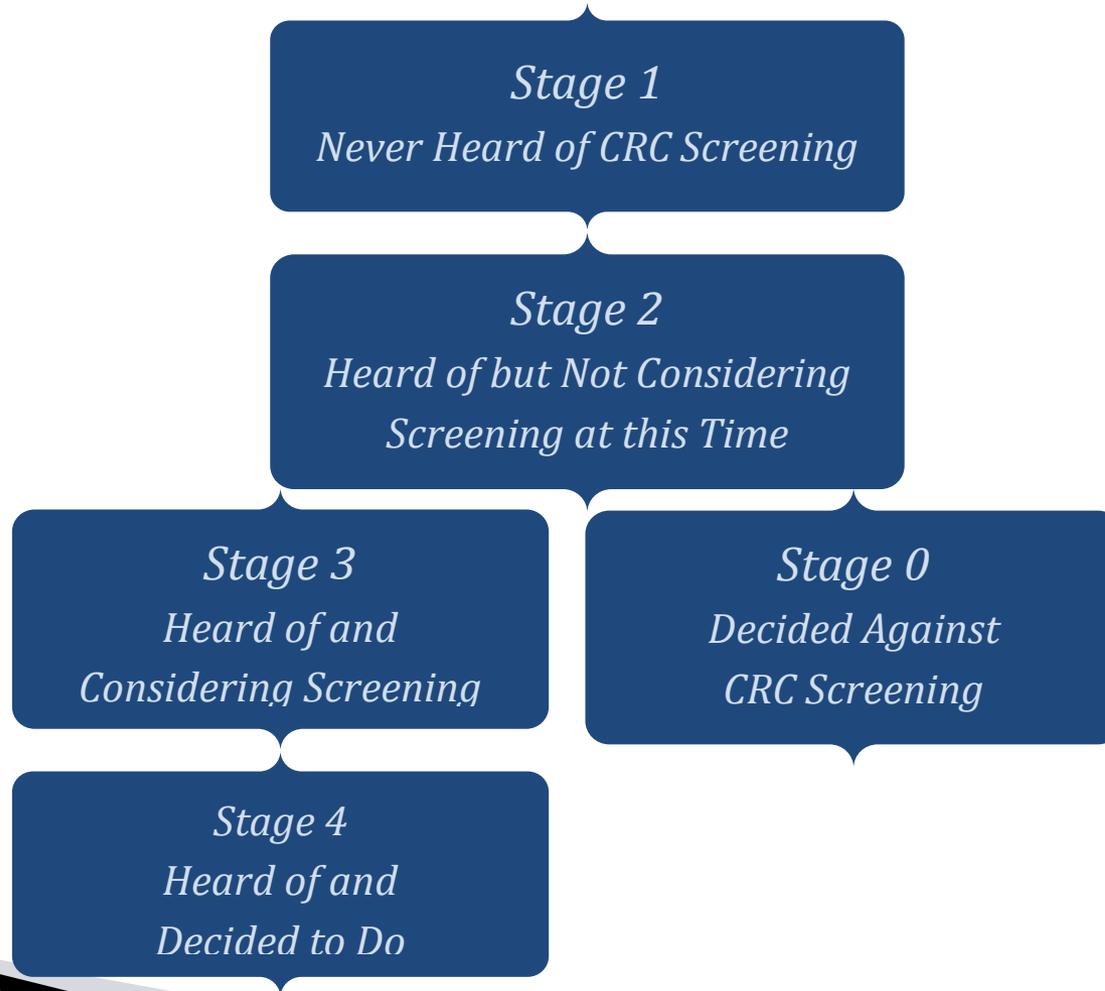
#4 An Effective Communication System

Options for Action

- Stage-based communication
 - Shared Decisions, Informed Decisions, Decision Aids
 - Staff Involvement
- 

An Effective Communication System

A Decision Stage Model for CRC Screening



An Effective Communication System

- Shared Decisions, Informed Decisions, Decision Aids
 - Explore client preferences
 - Clients who place a high value on accuracy prefer colonoscopy.
 - Clients who place a high value on convenience, privacy, or reassurance from frequent testing benefit from a home FOBT kit.
 - A patient's preference guided by a physician is a shared decision.

Decision Aids – few decision-making tools are ready for mass distribution.

An Effective Communication System

➤ Staff Involvement

- Standing orders can empower nurses and intake/discharge staff to give clients an FOBT, a referral for endoscopy, or a complete diagnostic work-up after a positive screen.
- Staff that interact with the client while they are in a patient room, can utilize that time to clarify CRC risk levels and ask simple questions that define what decision phase the client is in.

When staff are explicitly involved in making practice improvements, it becomes easier to achieve the desired goals.

Screening Guidelines

- ▶ CRC screening services (FOBT and Flexible Sigmoidoscopy) provided by law for all Medicare patients in January 1998.
- ▶ Medicare coverage for CRC screening colonoscopies for all, not just high risk individuals, began July 1, 2001.
- ▶ Most third-party payers reimburse for an FOBT and sigmoid exam in asymptomatic individuals. (Laws 2007, LB247, §86.; June 1, 2007)

Screening Guidelines

(Average Risk Women and Men Ages 50 and older)

Test	Interval (Beginning at age 50)	Comment
Fecal Occult Blood Test (FOBT) *** and Flexible Sigmoidoscopy	FOBT every year and flexible sigmoidoscopy every 5 years	Flexible sigmoidoscopy together with FOBT is preferred compared with FOBT or flexible sigmoidoscopy alone. All positive tests should be followed with colonoscopy. * **
Flexible Sigmoidoscopy	Every 5 years	Sigmoidoscopy provides an opportunity to visualize, sample, and/or remove significant lesions in the portion of the colon that is within reach of the sigmoidoscope. All positive tests should be followed up with colonoscopy. *
Fecal Occult Blood Test (FOBT) ***	Every year	The recommended take-home multiple sample method should be used. All positive tests should be followed up with colonoscopy.* **
Colonoscopy	Every 10 years	Colonoscopy provides an opportunity to visualize, sample, and/or remove significant lesions.
Double-Contrast Barium Enema (DCBE)*	Every 5 years	All positive tests should be followed up with colonoscopy.

www.aca.gov/screening guidelines Source: Smith et al, 2003

Screening Guidelines

- ▶ *A double-contrast barium enema (DCBE) alone, or the combination of flexible sigmoidoscopy and DCBE are acceptable alternatives to colonoscopy.
- ▶ **There is no justification for repeating FOBT in response to an initial positive finding.
- ▶ ***FOBT, as it is sometimes done in physicians' offices, with the single stool sample collected on the fingertip during a digital rectal examination, is not an adequate substitute for the recommended at-home procedure of collecting two samples from each of the three consecutive specimens.

Test your knowledge

If an FOBT kit is returned and one window only is positive, the test should be repeated

- A. True
- B. False

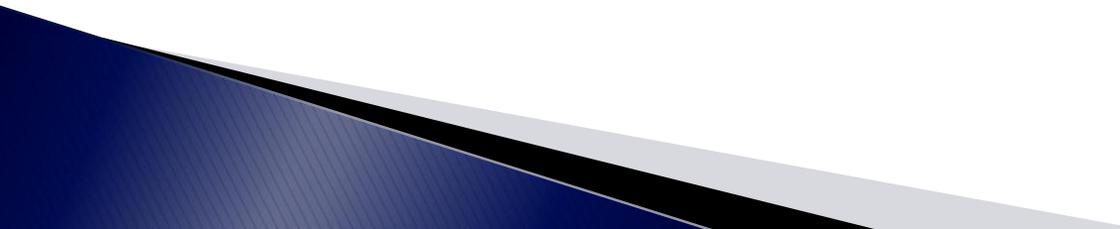
B. False - all positive should be followed with complete diagnostic colonoscopy

Test your knowledge

A 50 year old woman whose uncle was diagnosed with an adenomatous polyp at age 55 is at the following risk for colon cancer

- A. average
- B. increased
- C. high

A. Average



Screening Guidelines

(Women and Men at Increased Risk)

Increased Risk	Recommendation	Age to Begin	Comments
People with a single, small (<1 cm) adenoma	Colonoscopy*	3–6 years after the initial polypectomy	If the exam is normal, the patient can thereafter be screened as per average-risk guidelines
People with a large (1 cm +) adenoma, multiple adenomas, or adenomas with high-grade dysplasia or villous change.	Colonoscopy*	Within 3 years after the initial polypectomy	If normal, repeat examination in 3 years; If normal then, the patient can thereafter be screened as per average-risk guidelines.
Personal history of curative-intent resection of colorectal cancer	Colonoscopy*	Within 1 year after cancer resection	If normal, repeat examination in 3 years; If normal, repeat examination every 5 years.
Either colorectal cancer or adenomatous polyps in any first-degree relative before age 60, or in two or more first-degree relatives at any age (if not a hereditary syndrome).	Colonoscopy*	Age 50, or 10 years before the youngest case in the immediate family	Every 5–10 years. Colorectal cancer in relatives more distant than first-degree does not increase risk substantially above the average-risk group.

Screening Guidelines

(Women and Men at Increased Risk)

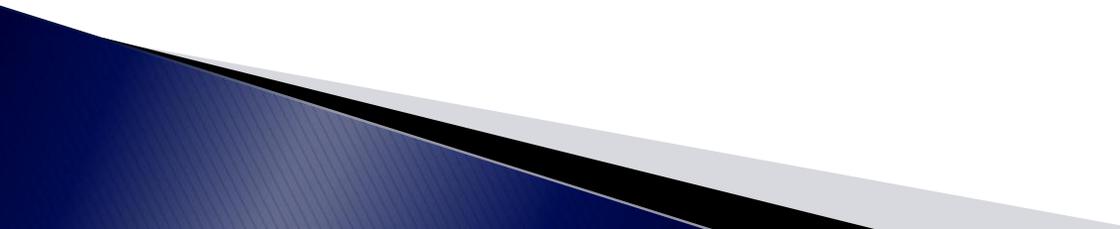
- ▶ *If colonoscopy is unavailable, not feasible or not desired by the patient, double-contrast barium enema (DCBE), or the combination of flexible sigmoidoscopy and DCBE are acceptable alternatives.
- ▶ Adding flexible sigmoidoscopy to DCBE may provide a more comprehensive diagnostic evaluation than DCBE alone in finding lesions.
- ▶ A supplementary DCBE may be needed if a colonoscopic exam fails to reach the cecum, and a supplementary colonoscopy may be needed if a DCBE identifies a possible lesion or does not adequately visualize the entire colorectum.

Test your knowledge

A 45 year old woman whose father was diagnosed with CRC at age 70 is at the following risk for colon cancer

- A. average
- B. increased
- C. high

A. Increased



Screening Guidelines

Women and Men at High Risk

High Risk	Recommendation	Age to Begin	Comments
Family history of familial adenomatous polyposis (FAP)	Early surveillance with endoscopy, and counseling to consider genetic testing	Puberty	If the genetic test is positive, colectomy is indicated. These patients are best referred to a center with experience in FAP management.
Family history of hereditary non-polyposis colon cancer (HNPCC)	Colonoscopy and counseling to consider genetic testing	Age 21	If the genetic test is positive or if the patient has not had genetic testing, every 1–2 years until age 40, then annually. These patients are best referred to a center with experience in HNPCC management.
Inflammatory bowel disease; chronic ulcerative colitis; Crohn's disease	Colonoscopy with biopsies for dysplasia	Risk becomes significant 8 years after the onset of pancolitis, or 12–15 years after the onset of left-sided colitis	Every 1–2 years. These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

Importance of the Colonoscopy Report

- ▶ Determines if the screening was adequate
 - Adequate prep
 - Cecum reached
 - All polyps removed
- ▶ Determines the next colorectal screening
 - Failure to reach cecum requires either repeat endoscopy or immediate DCBE
- ▶ Determines frequency
 - What type of polyps were found
 - Number found

Test your knowledge

What screening modality offers the greatest sensitivity and specificity and should be recommended to those at increased risk?

- A. FOBT
- B. FOBT/Flexible sigmoidoscopy
- C. Flexible Sigmoidoscopy
- D. Colonoscopy
- E. Double contrast barium enema

REMEMBER

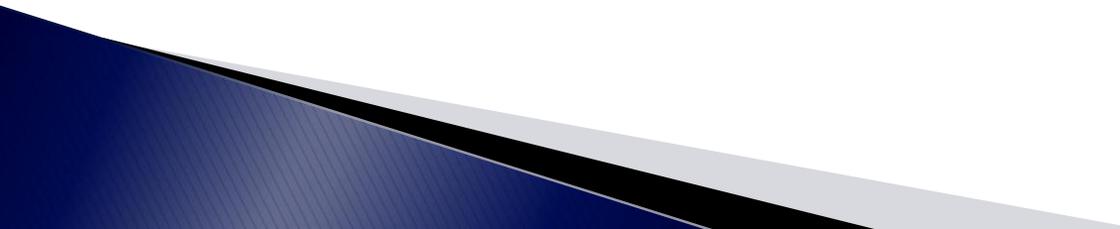
While there are guidelines set for CRC screening, any screening the client is willing to do is better than NO screening at all!

REMEMBER!

As a clinician, you can make a difference in preventing colon cancer.

Remind your clients of the importance of getting screened for colorectal cancer.

Thank You!



References

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